STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 02 B. WING	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/04/12 Facility Number: 002661 Provider Number: 155783 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist Robert Sutton, Life Safety Code Specialist Trainee At this Life Safety Code survey, Greenleaf Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) 2000 Edition, Chapter 18, New Health Care Occupancies and 410 IAC 16.2.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The building was constructed in 2010, is adjacent to an assisted living unit and separated by a two hour rated fire wall. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 54 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. The facility had an unsprinklered garage providing storage of maintenance supplies. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/11/12. The facility was found not in compliance with the aforementioned regulatory			

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	requirements as evidenced by the following:			

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K0027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 Based on observation and interview, the facility failed to ensure 2 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 25 residents in the 200 hall and residents in the main dining room with a capacity of 40 residents. Findings include:	K0027	**K-27 No residents were negatively affected.** · **The two sets of smoke barrier doors were readjusted and astragal strip put on both doors.** · **The two sets of smoke barrier doors were readjusted and astragal strip put on both doors leaving no more than 1/8" opening.** · **During fire alarm checks the maintenance director and or his designee will monitor during monthly drills.** · **Monthly x 3months the maintenance director and or his designee will bring monthly fire drill audits to Quality Assurance meeting and if now issues found then the team will decide to continue to monitor issue resolved.**	10/05/2012

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	Based on observation with the Director of Plant Operations on 10/04/12 at 1:27 p.m. and then again at 2:05 p.m., the 200 hall smoke barrier doors and the restorative dining room corridor smoke barrier doors had a three eights inch gap between the doors when closed. Measurement were verified by the Director of Plant Operations at the time of observations. 3.1-19(b)			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 9 doors in the path of egress equipped with a magnetic locking system remained unlocked with activation of the building fire protective signaling system. LSC 18.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect residents in the family area lounge with a seating capacity of 16. Findings include: Based on an observation with the Director of Plant Operations on 10/04/12 at 3:24 p.m., the family area lounge exit doors which were equipped with a magnetic locking system failed to remain unlocked when the fire alarm system was	K0038	· **K-38** · **There were no residents negatively affected when the lounge exit door equipped with a magnetic locking system failed to remain unlocked when fire alarm system was placed in silence mode.** · **Vanguard was called in and found wiring problem and repaired so that lounge doors remain unlocked when fire alarm activated.** · **During fire alarm checks the maintenance director and or his designee monthly and as needed. Koorshen monitoring company will monitor during quarterly inspections.** · **Monthly x 3 months the maintenance director and or his designee will bring monthly fire drill audits to Quality Assurance meeting and if no issues found then the team will decide to continue to monitor or issue resolved.** · **10/12/12**	10/12/2012

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	placed in silence mode. This was confirmed by the Director of Plant Operations at the time of observation. 3.1-19(b)			

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation. interview and record review; the facility failed to ensure 2 of 2 single fire doors were arranged to automatically close and latch. LSC requires 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects residents in the restorative dining room with a capacity of 11 residents and in the main dining room with a capacity of 40 residents. Findings include: Based on an observations with the Director of Plant Operations on 10/04/12 at 2:07 p.m., the	K0044	**K-44** · **No residents were negatively affected by main dining room door and the kitchen door not latching correctly.** · **The maintenance director adjusted door closers and the hinges were tightened.** · **During monthly checks the maintenance director and or designee will check to ensure the doors close accordingly.** · **Monthly x 3 months the maintenance director and or his designee will bring monthly audits to Quality Assurance meeting and if no issues are found then the team will decide to continue to monitor or resolve issue.** · **10/12/12**	10/12/2012

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	following single fire doors failed to latch into the frame: a. the fire door between the main dining room and the kitchen failed to latch into the frame when tested. Based on an interview with the Director of Plant Operations at the time of observation, he recently adjusted the self closer to slow the closing of the door to prevent the door from slamming which scared the dining room residents. b. the fire door between the main dining room and the restorative dining room failed to latch when tested. Based on an interview with the Director of Plant Operations at the time of observation, the door hit the door frame and the hinges needed to be tightened. Based on review of the facilities construction plans at 3:00 p.m. on 10/04/12 with the Director of Plant Operations, these fire doors were in a two hour fire rated wall. 3.1-19(b)			

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K0045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 9 emergency exits. This deficient practice could affect 18 residents on the 300 hall who could be evacuated through either the 300 hall exit or the service hall emergency exit. Finding include: Based on an observation with the Director of Plant Operations on 10/04/12 at 12:50 p.m., the exterior exit discharge path for the service hall was equipped with one light fixture with a single bulb. Additionally, the 300 hall exit has a ninety degree turn that continues down the side of the building joining with the service hall exit sidewalk. This portion of the sidewalk does not have exterior light fixtures. Based on an interview with the Director of Plant Operations at the time of	K0045	**K-45 · No residents were negatively affected light fixture by exterior exit by service hall. · The parking lot lights do work off the emergency generator. These parking lot lights give light to the 300 hall exit and that 90 degree turn, the parking lights do automately come on when emergency generator runs giving illumination to the means of egress on 300 hall.· During weekly generator checks to ensure the parking lot lights do work, the one fixture was replace with a two bulb fixture. · Monthly x 3 months the maintenance director and or his designee will bring weekly audits to Quality Assurance meeting and if no issues are found then the team will decide to continue to monitor or resolve the issue with current system. · 10/19/12**	10/19/2012

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	observation, the exit discharge path sidewalk from the 300 hall measures one hundred feet. 3.1-19(b)			

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K0046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on observation and interview, the facility failed to provide exterior emergency lights for 9 of 9 emergency exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could all 54 residents. Findings include: Based on observation with Director of Plant Operations on 10/04/12 during a tour of the facility from 12:50 p.m. to 3:25 p.m., exterior light fixtures were observed at all of the emergency exits. Based on an interview with the Director of Plant Operations at the time of observations, he could not confirm the exterior lights were connected to the emergency generator to provide emergency lighting. 3.1-19(b)	K0046	**K-46** · **No residents were negatively affected** · **The maintenance director has tested the emergency generator and confirmed that the exterior light fixtures due provide emergency lighting.** · **During weekly generator checks the maintenance director and or designee will check to ensure exterior light are provided when emergency generator is ran.** · **Monthly x 3 months the maintenance director and or his designee will bring weekly audits to the Quality Assurance meeting and if no issues are found then the team will decide to continue to monitor or resolve the issue with current system.** · **10/19/12**	10/19/2012

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K0047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1. Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified as "No Exit." LSC 7.10.8.1 requires any door that is neither an exit or a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads; NO EXIT. This deficient practice affects residents evacuated through the corridor between Heath Care and the Assisted Living unit. Findings include: Based on observation with the Director of Plant Operations on 10/04/12 at 2:25 p.m., the double doors in the corridor between Health Care and the Assisted Living unit lead to the outside but was not considered an emergency exit. There was not a sign to identify the doors as "NO EXIT" for emergency purposes.	K0047	**K-47** · **No residents were negatively affected.** · **No exit signs have been placed on double doors between in the corridor between Health Care and the Assisted Living.** · **These were the only doors affected.** · **10/19/12**	10/19/2012

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K0154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 54 of 54 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(c)2. requires an approved fire watch. NFPA 25, A-11-5(c)2 explains a fire watch should consist of trained personnel who continuously patrol the effected area. Ready access to fire extinguishers and the ability to promptly notify the fire	K0154	**K-154 · No residents were negatively affected · All nursing stations have fire watch procedure in binders.The correct fire watch policy is at all nurses station and the Director of plant operations has inserviced staff on the correct procedure to be followed. · All new staff will be in serviced in general orientation and yearly thereafter by the maintenance director and or designee. · All staff have been in serviced on the correct fire watch policy and procedure of the campus and all binders have the correct and current fire watch policy. · Director of Maintenance will ensure all staff are inserviced on this procedure.· 11/02/12**	11/02/2012

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	department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice affects all residents. Findings include: Based on record review with the Director of Plant Operations and the Administrator on 10/04/12 at 12:25 p.m., the facility did have a written policy and procedure for an impaired sprinkler system but the plan did not state the person conducting the fire watch be properly trained. Based on interview with the Director of Plant Operations and the Administrator at the time of record review, no other documentation was available for review. 3.1-19(b)			

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K0155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 54 of 54 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 18.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 18.7.1.2 through 18.7.2.3 shall apply. 18.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 18.7.2.3	K0155	**K-155** · No residents were negatively affected · **All nursing stations have the correct and current fire watch procedure in binders, with the current forms to be used.** · **All new staff will be in serviced in general orientation and yearly thereafter by the maintenance director and or designee.** · **All staff have been in serviced on the correct fire watch policy and procedure.** · Director of Maintenance and or there designee will ensure all staff are inserviced on hire and yearly. · **11/02/12**	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 02 B. WING	10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	requires health care personnel be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all residents. Findings include: Based on record review with the Director of Plant Operations and the Administrator on 10/04/12 at 12:25 p.m., the facility did have a written policy and procedure for an impaired fire alarm system but the plan did not state the person conducting the fire watch be properly trained. Based on interview with the Director of Plant Operations and the Administrator at the time of record review, no other documentation was available for review. 3.1-19(b)			